

## **CONSUMER DISCLOSURE**

From time to time, Protective Life (we, us or Company) may be required by law or business practices to

provide to you certain written notices, disclosures, authorizations, acknowledgements, or other documents (referred to collectively herein as “documents”). These documents may be delivered to you either in paper or, with your consent, electronically.

Described below are the terms and conditions for providing to you such notices and disclosures electronically through the Adobe Systems Inc. (Adobe) electronic signing system or other methods utilized by the Company from time to time. Please read the information below and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by signing this document.

### **With Your Consent, Documents Will Be Sent to You Electronically**

If you consent to receive documents from us electronically, then we will provide them to you through the Adobe system or another mutually agreeable method.

Once you consent to receive documents from us electronically, we will not, as a matter of course, send the documents to you in both electronic and paper format. This is to reduce the chance of delivery errors.

### **Updating Your E-mail Address for Electronic Delivery**

If you need to update the e-mail address to which we send documents electronically to you, you must:

e-mail your request to [TeleLife@protective.com](mailto:TeleLife@protective.com) and include in the body of the message your previous e-mail address and your new e-mail address.

### **Getting paper copies**

Even if you opt to receive documents from us electronically, you may obtain a paper copy of any document we provide or make available to you electronically. You will have the ability to download and print those documents during your Adobe signing session and Adobe will email you the complete signed document after you have completed the Adobe signing process. You may request from us a paper copy of any document we provide or make available to you electronically.

To request paper copies of documents we previously provided to you electronically, you must e-mail your request to [TeleLife@protective.com](mailto:TeleLife@protective.com) and in the body of your request, you must state your email address, full name, US Postal address, and telephone number.

### **Withdrawing your consent**

You are never obligated to give your consent to receive documents from us electronically. If you choose to receive documents from us in paper format, then we will send them to you through the paper mail delivery system.

If you consent to receive documents from us electronically and later decide you would prefer to receive them from us in paper format, then you may withdraw your consent at any time, and we will send our documents to you in paper format through the paper mail delivery system.

### **Consequence of Opting for Paper Rather Than Electronic Delivery of Documents**

Because paper mail delivery systems are slower than electronic mail delivery systems, if you elect to receive documents from us in paper rather than electronic form, you can expect longer processing time for transactions.

### **To Withdraw Your Consent to Receive Documents Electronically**

To inform us that you no longer wish to receive documents from us electronically and that you prefer to receive them in paper format instead, you may *either*:

- i. Decline to sign a document from within your Adobe session by selecting the Alternative Action of “I will not esign”, and in the message box, enter your reason for withdrawing your consent; *OR*
- ii. Send an email to [TeleLife@protective.com](mailto:TeleLife@protective.com) and include in the body of the request your email address, full name, US Postal address, and telephone number.

### **Required hardware and software\*\***

Operating Systems: Windows® 8, Windows® 10, Mac OS® X v10.9 or later

Browsers: Chrome (Windows and Mac), Final release versions of Internet Explorer® 11 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 7.0 or above (Mac only)

Mobile app: Adobe Sign: for iOS or Android

PDF Reader: Adobe® Reader 9.0 or later

Enabled Security Settings: Allow per session cookies

\*\* These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Prerelease (e.g. beta) versions of operating systems and browsers are not supported.

**Acknowledging your access and consent to receive materials electronically**

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page

for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by signing below.

By signing below, I confirm that:

I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC CONSUMER DISCLOSURES document; and

I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

Until or unless I rescind my consent to do business electronically with Protective Life as described above, I consent to receive electronic delivery of all notices, disclosures, authorizations, acknowledgements, and other documents from Protective Life, to the extent permitted by law.

X Flora Tarcila E. Apelo  
Flora Tarcila E. Apelo (Sep 28, 2019)

Proposed Insured **Flora Tarcila E Apelo**

X 09/28/2019

Date

**Protective Life Insurance Company**  
2801 Highway 280  
South Birmingham, AL  
35223 (888) 800-6608



September 28, 2019

Flora Tarcila E Apelo  
140 Mirror Ct  
Patterson, CA 95363

POLICY NUMBER: LU5343591  
APPLICANT: Flora Tarcila E Apelo

|                                |
|--------------------------------|
| <b>IMPORTANT – PLEASE READ</b> |
|--------------------------------|

Dear Flora Tarcila E Apelo

Thank you for choosing Protective Life as your insurance provider. It is our mission to provide you with the financial security you need so you can protect tomorrow, while you embrace today. Before your application can be reviewed and fully underwritten we ask that you sign your application by clicking on the signature areas designated by the arrows. Instructions on the signature process are included for your convenience if needed. Once this process has been completed we can begin taking the necessary steps to underwrite your life insurance application.

We ask that your application is signed within 30 days of this correspondence, as underwriting cannot begin until we have received your electronically signed application.

Follow these instructions:

- ☐ Select signature fields and enter your name to apply your signature
- ☐ Enter city, state, and/or date where needed
- ☐ After all fields have been completed, click the button to submit your signed application

If you have questions or would like additional assistance please feel free to contact us at 888-800-6608 opt 3 or email [resourcecenter@protective.com](mailto:resourcecenter@protective.com).

Sincerely,  
Protective Life

Policy Number: LU5343591

Protective Life and Annuity Insurance Company

P.O. Box 830619

Birmingham, AL 35283-0619

**INDIVIDUAL LIFE INSURANCE APPLICATION (PART I)****1. Proposed Insured**

|                                           |                     |
|-------------------------------------------|---------------------|
| a. Title                                  |                     |
| b. First Name                             | Flora Tarcila       |
| c. Middle Name                            | E                   |
| d. Last Name                              | Apelo               |
| e. Suffix                                 |                     |
| f. Gender                                 | F                   |
| g. Birthdate                              | 04/06/1964          |
| h. Birth State                            | FC                  |
| i. Birth Country                          | Philippines         |
| j. Marital Status                         | Married             |
| k. Phone 1                                |                     |
| l. Phone 2                                | (408) 564-9926      |
| m. Phone 3                                | (408) 966-9099      |
| n. Best Phone and Time to Call (am/pm)    |                     |
| o. Driver's License Number and State      | D3119796 CA         |
| p. Social Security Number / Tax ID Number | 413-83-6677         |
| q. Email Address                          | ftapelo@aol.com     |
| r. Residential Street Address             | 140 Mirror Ct       |
| s. Residential City, State, Zip Code      | Patterson, CA 95363 |
| t. Length of Time at Residence            | 8 years             |

**2. Employment Information**

|                             |               |
|-----------------------------|---------------|
| a. Employer's Name          | N/A           |
| b. Street Address           |               |
| c. City, State, Zip Code    | ,             |
| d. Occupation               | RN/Retired    |
| e. Number of Years Employed | Over 10 years |
| f. Annual Income            | \$68,400      |
| g. Net Worth                | N/A           |

**3. Owner (if other than Proposed Insured)**

|                                           |                       |
|-------------------------------------------|-----------------------|
| a. Name                                   | Flora Tarcila E Apelo |
| b. Date of Trust                          |                       |
| c. Birthdate                              | 04/06/1964            |
| d. Relationship to Proposed Insured       | Insured               |
| e. Social Security Number / Tax ID Number | 413-83-6677           |
| f. Email Address                          | ftapelo@aol.com       |
| g. Street Address                         | 140 Mirror Ct         |
| h. City, State, Zip Code                  | Patterson, CA 95363   |

Policy Number: LU5343591

**4. Beneficiary Designations – If multiple beneficiaries are named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified. For additional space, use the Remarks and Explanations Section.**

**a) Primary Beneficiary(ies): Include**

|                                                                                                                                          |                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| 1. Name(s)<br>Address(es)<br>Phone Number(s)<br>Birthdate(s)<br>Social Security Number(s)<br>Relationship(s) to Insured<br>Percentage(s) | Rene A Apelo<br><br><br><br><br>Husband<br>100.00% |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|

**b) Contingent Beneficiary(ies): Include**

|                                                                                                                                          |                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. Name(s)<br>Address(es)<br>Phone Number(s)<br>Birthdate(s)<br>Social Security Number(s)<br>Relationship(s) to Insured<br>Percentage(s) | Surviving Children of the Insured - Shared Equally<br><br><br><br><br>Child<br>100.00% |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|

**5. Plan of Insurance**

|                                                                                                                                                      |                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| a. Name of Product:                                                                                                                                  | Member Advantage Life Term EX20 |
| b. Face Amount:                                                                                                                                      | \$500,000                       |
| c. If Term or Alternative to Term, Indicate Years:                                                                                                   | 20                              |
| d. Underwriting Class Quoted:<br>(Protective will issue the best underwriting class.)                                                                | Preferred                       |
| e. Death Benefit: (Level or Increasing)                                                                                                              |                                 |
| f. Section 1035: Yes or No                                                                                                                           | No                              |
| g. 1035 Loan Transfer : Yes or No                                                                                                                    |                                 |
| h. CVAT (If not chosen, the Guideline Premium Test will apply, subject to product availability.)                                                     | No                              |
| i. Is Proposed Insured Requesting Additional Benefits, Riders, or Child Coverage? (If Yes, you must complete the Rider Worksheet.)                   | No                              |
| j. Premium Payment Mode and Amount:<br>(Annual, Quarterly, Semi-Annual, Monthly (pre-authorized withdrawal only) or Cash included with application.) | \$83.68 Monthly                 |

6. What is the purpose of the insurance?  
**Personal** – Family/Estate Protection, Asset Transfer.  
**Business** – Key Man, Buy-Sell, etc.)

Other Personal

**7. Regarding the Proposed Insured – use the Remarks and Explanations Section for Yes answers or additional details.**

a) Should this application be considered a potential replacement or modification of any existing life insurance or annuity?  
(If Yes, complete any State required replacement forms and comparison statements.)

Yes

Policy Number: LU5343591

b) **List all life insurance in force on your life.**

(Please list insurance policy information, whether owned by you or not.

**If None, insert None.)**

|    |                                                                                                 |                                                                       |
|----|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. | Company:<br>Policy Number:<br>Replace (Yes or No):<br>Amount:<br>Insurance Type:<br>Issue Date: | AAA LIFE INS. CO.<br>4003827716<br>Yes<br>\$1,000,000<br>term<br>2004 |
|----|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|

c) Is there any application for any other life insurance on your life now pending or being considered with this or any other company?  
If Yes,

No

|                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------|--|
| 1. Company Name:<br>2. Amount of Coverage:<br>3. Total Amount to be Placed:<br>4. Purpose of Coverage: |  |
|--------------------------------------------------------------------------------------------------------|--|

*Remarks and Explanations to any Yes answers.*

Replacing: Yes

Agent: 000Q0DC331 YOO, BYUNGSEUNG 100

Proposed insured is the payor.

Net worth is - 485,000 due to mortgage, credit card debt and car loans.

Country of birth: Philippines

Submitted on 09/23/2019

**Disclosure Notes**

Net worth is - 485,000 due to mortgage, credit card debt and car loans.

**General**

Is the purpose of this insurance for business? No

Is there any application for any other life insurance on your life now pending or being considered with this or any other company? No

**Occupation List**

Retired: At which age did you retire? 55

Retired: What was your occupation prior to retirement? Registered Nurse

Retired: What was the reason for retirement? Client decided to retire

Retired: What is your source of income? Retirement

*Home Office Endorsements (Home Office Use Only)*

#### **DECLARATIONS**

I have read or have had read to me the completed Application before signing below. I represent that all statements and answers made in all parts of this application are full, complete and true, to the best of my knowledge and belief and I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance goes into effect. It is agreed that:

1. All such statements and answers shall be the basis of any insurance issued, and my (our) answers are material to the decision as to whether the risk is accepted by Protective Life.
2. No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
3. Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.
4. No insurance shall take effect unless: (1) a policy is delivered to the Owner; (2) the full first premium is paid while the proposed insured(s) is (are) alive; **and** (3) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the attached Conditional Receipt Agreement and the Conditional Receipt Agreement is delivered to the Owner, the terms of the Conditional Receipt Agreement shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
5. I have reviewed the attached Conditional Receipt Agreement and understand and agree that it provides a **limited** amount of life insurance for a **limited** period of time, and that such coverage is subject to the terms and conditions set forth in the Conditional Receipt Agreement.
6. The representative taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Conditional Receipt Agreement.



Policy Number: LU5343591

**IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION**

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

Signed At Patterson CA Date 09/28/2019  
*City and State* *Mo./Day/Yr.*

(X) Flora Tarcila E. Apelo (X) \_\_\_\_\_  
Flora Tarcila E. Apelo (Sep 28, 2019)  
Proposed Insured (Sign Name in Full) Owner (if other than the Proposed Insured)  
Flora Tarcila E Apelo Flora Tarcila E Apelo

(X) \_\_\_\_\_  
Parent/Guardian

**AGENT/BROKER:**

Will this policy replace or change any existing life insurance policy(ies) or annuity(ies)? ☒ Yes ☐ No

What is your relationship to the Proposed Insured? \_\_\_\_\_

Protective Life 000Q0DC331  
Agent/Broker Name Agent/Broker Number

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of Protective Life was obtained 09/22/2019 (date)

at 11:14:05 AM CDT (time). Agent/Broker Phone Number (999) 999-9999

Broker Dealer or Broker General Agent (if applicable) AFFINITY PARTNERSHIP

**SUPPLEMENTAL APPLICATION (PART II)**

Proposed Insured Name: Flora Tarcila E Apelo

Policy Number: LU5343591

1. Are you a U.S. citizen? ☒ Yes ☐ No
2. Are you a citizen of any country other than the United States or Canada? ☐ Yes ☒ No
3. Do you plan to **reside** outside the U.S. or Canada in the next 12 months? ☐ Yes ☒ No
4. Do you plan to **travel** outside the U.S. or Canada in the next 12 months? ☒ Yes ☐ No

Philippines:

Would you consider traveling to war zones or hazardous areas? No

Please state dates. February 2020 ( 3 weeks)

For what purpose is this foreign travel or residence? Please give a brief description of your duties while traveling or residing abroad. High School Reunion

5. Have you filed for or declared bankruptcy in the past ten (10) years? ☐ Yes ☒ No
6. Have you ever had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way? ☐ Yes ☒ No
7. Have you used tobacco, nicotine or marijuana, of any kind, over the last 5 years? ☐ Yes ☒ No

8. What is the name and address of your primary physician? (If none, indicate "None")

Dr. Thao Thanh Pham 770 E Calaveras Blvd, Milpitas, CA 95035 (408) 945 - 2933

9. Why did you last visit or consult with your primary physician?

Stye:

Is this condition resolved or improving with no further testing or follow-up planned? Yes

Date: September 23, 2019

Within the past 10 years, have you consulted a physician for your Stye? Yes

Dr Thao Thanh Pham 770 E Calaveras Blvd Milpitas, California 95035, United States of America Phone:408-945-2933 Last Visit: 9/2019

Did any other physician treat you for your Stye? No

10. Why did you last consult any physician?

See Application Part II Question # 9 for details of most recent visit:

Within the past 10 years, have you consulted a physician for your See Application Part II Question # 9 for details of most recent visit? No

11. What is your current height and weight?  
Height: 5'02"  
Weight: 128
12. Have you gained or lost more than 10 pounds in the past year? ☐ Yes ☒ No
13. Females - are you pregnant? ☐ Yes ☒ No
14. Do you know your last blood pressure reading? ☒ Yes ☐ No  
Blood Pressure (last reading known):  
Have you ever been diagnosed with high blood pressure or hypertension? No  
What was your most recent blood pressure reading (systolic)? 114  
What was your most recent blood pressure reading (diastolic)? 70  
Within the past 10 years, have you consulted a physician for your Blood Pressure (last reading known)? No
15. Do you know your last cholesterol reading? ☐ Yes ☒ No  
Cholesterol (last reading unknown):  
Have you ever been told you have high cholesterol? No  
Within the past 10 years, have you consulted a physician for your Cholesterol (last reading unknown)? No
16. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
- a. Any disorder or disease of the brain, spinal cord or nervous system such as chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, Multiple Sclerosis (MS), motor neuron disease also known as Amyotrophic Lateral Sclerosis (ALS), Transient Ischemic Attack (TIA), Parkinson's disease, muscular dystrophy, Alzheimer's disease or dementia, epilepsy or sleep disorder? ☐ Yes ☒ No
  - b. Any disorder or disease of the heart, blood vessels, or circulatory system such as heart attack, angina, phlebitis, peripheral vascular disease, palpitations, stroke, heart murmur, rheumatic fever, pulse irregularity, chest pain? ☐ Yes ☒ No
  - c. Any disorder or disease of the respiratory system such as asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, pneumonia, tuberculosis (TB) or sleep apnea? ☐ Yes ☒ No
  - d. Any disorder or disease of the stomach, liver, gall bladder, intestines, rectum, pancreas or abdominal organs such as Barrett's esophagus, Crohn's disease, hepatitis, jaundice, intestinal bleeding, ulcer, colitis or diverticulitis? ☐ Yes ☒ No

- e. Any disorder or disease of the urinary organs including kidneys, bladder, urinary tract and ureters, blood or sugar in the urine or chronic inflammation? ☐ Yes ☒ No
- f. Any disorder or disease of the skeletal system such as arthritis, fibromyalgia, gout, lupus, rheumatoid arthritis, osteoporosis, joints, bones, spine, muscles, amputation, deformity? ☐ Yes ☒ No
- g. Any disorder or disease of the eyes, ears, nose or throat? ☒ Yes ☐ No
- Sinusitis:
- Within the past 10 years, have you consulted a physician for your Sinusitis? Yes
- Dr Thao Thanh Pham 770 E Calaveras Blvd Milpitas, California 95035, United States of America Phone:408-945-2933 Last Visit: 9/2019
- Did any other physician treat you for your Sinusitis? No
- h. Any disorder or disease of the endocrine system such as diabetes, thyroid, lymph or other glands? ☐ Yes ☒ No
- i. Any disorder or disease of the skin such as eczema, cyst, polyp, lump or other growth? ☐ Yes ☒ No
- j. Any psychiatric or mental health, nervous or emotional disorders or diseases such as suicidal thoughts or attempts of suicide, bipolar, obsessive-compulsive, anxiety, ADD/ADHD, depression, psychosis, anorexia or bulimia? ☐ Yes ☒ No
- k. Females: any diseases of the reproductive system or any gynecological disorders such as irregular pap smear, toxic shock syndrome, fibroids, abnormal menstrual bleeding, or disorder of the uterus, cervix, ovaries or breasts? ☐ Yes ☒ No
- l. Males: any disease of the prostate or reproductive system? ☐ Yes ☐ No
- Question not required by company.
- m. Any cancer, tumor, nodule, melanoma, skin cancer or any other malignant disorder? ☐ Yes ☒ No
- n. Any sexually transmitted disorders or diseases? ☐ Yes ☒ No
- o. Any disorders or diseases of the blood or immune system such as anemia, blood clots, bleeding, had a transfusion or been refused as a donor, immune deficiency, leukemia, or lymphoma (excluding those related to the Human Immunodeficiency Virus)? ☐ Yes ☒ No

17. Have you been diagnosed or treated by a member of the medical profession in the past year for:

- a. Immune deficiency, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions, or unexplained swelling of the lymph glands? ☐ Yes ☒ No

- b. Human Immunodeficiency Virus (HIV), AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☒ No

18. Have you ever:

- a. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician? ☐ Yes ☒ No
- b. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of prescribed or non-prescribed drugs? ☐ Yes ☒ No
- c. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol? ☐ Yes ☒ No
- d. Been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs? ☐ Yes ☒ No
- e. Been advised to reduce your consumption of alcohol? ☐ Yes ☒ No
- f. Been advised to reduce your consumption of drugs? ☐ Yes ☒ No

19. Excluding HIV, minor injuries, minor virus or common colds, within the past five (5) years, have you:

- a. Been treated, examined or advised by a member of the medical profession for any condition other than as previously stated? ☒ Yes ☐ No

Hemorrhoids:

Within the past 10 years, have you consulted a physician for your Hemorrhoids? Yes

Kaiser Permanente Santa Clara Medical Center and Medical 700 Lawrence Expy Santa Clara, California 95051, United States of America Phone:408-851-1000 Last Visit: 1/2019

Did any other physician treat you for your Hemorrhoids? No

- b. Been advised by a member of the medical profession to get specified medical care, hospitalization, surgery or diagnostic test, which has not been completed? ☐ Yes ☒ No
- c. Been an inpatient in a hospital, clinic, medical facility, extended stay facility, or any similar entity (excluding the E.R.)? ☐ Yes ☒ No
- d. Had any diagnostic test, surgery, biopsy, electrocardiogram (EKG), MRI, CT-Scan or X-ray? ☐ Yes ☒ No
- e. Been on or advised to be on any prescribed or non-prescribed medication or prescribed diet? ☒ Yes ☐ No

Medication:

Please list all medications and prescribed diets used, along with the reason(s), if not already disclosed. Zithromax - Sinsus

Within the past 10 years, have you consulted a physician for your Medication? Yes

Dr Thao Thanh Pham 770 E Calaveras Blvd Milpitas, California 95035, United States of America Phone:408-945-2933 Last Visit: 9/2019

Did any other physician treat you for your Medication? No

- f. Been unable to work, attend school or perform normal activities of life age or been confined at home? ☐ Yes ☒ No
- g. Made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition? ☐ Yes ☒ No
20. Have you had a parent or sibling diagnosed or treated by a member of the medical profession for heart disease or cancer? ☐ Yes ☒ No
21. Have you ever been convicted or are you awaiting trial for a felony, misdemeanor or infraction other than a traffic violation? ☐ Yes ☒ No
22. Have you had more than 2 moving violations or had any suspensions or revocations in the past 3 years? ☐ Yes ☒ No
23. Have you been arrested or convicted for reckless driving or driving under the influence of alcohol or drugs within the past 5 years? ☐ Yes ☒ No
24. Do you participate in any of the following sports or activities: aviation or aerial activities, scuba diving, racing, parachuting, sky diving, hang gliding, mountain climbing or rock climbing? ☐ Yes ☒ No

**I declare that the answers I have given are true to the best of my knowledge and belief and that I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance is in effect.**

**Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties, according to state law.**

Signed at: Patterson CA

City and State

Date: 09/28/2019

Mo./Day/Yr.

X Flora Tarcila E. Apelo  
Flora Tarcila E. Apelo (Sep 28, 2019)

X

Signature of Proposed Insured

Flora Tarcila E Apelo

Parent Signature if Proposed Insured is under age 15



Protective Life Insurance Company  
P.O. Box 830619  
Birmingham, AL 35283-0619

**SUPPLEMENT TO LIFE INSURANCE APPLICATION**

**APPLICATION SUPPLEMENT – PART I**

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s): Flora Tarcila E Apelo

For any policy to be issued as a result of this application:

- |                                                                                                                                                                                                                                                                                         | Yes                      | No                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|
| (1) Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy?<br>If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?<br>If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (3) Will a trust, including family trust, own this policy?<br>If Yes, complete the "Trust Certification" (Application Supplement – Part III)                                                                                                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies \$1,000,000 or more?<br>If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)                                                                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**SIGNATURES**

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in CA this 28 day of September, 2019  
(State) (Month) (Year)

Signature(s) of Proposed Insured(s): X Flora Tarcila E. Apelo  
Flora Tarcila E. Apelo (Sep 28, 2019)

X \_\_\_\_\_

Signature(s) of Owner(s)/Trustee(s): X \_\_\_\_\_  
(provide officer's title if policy is owned by a corporation) X \_\_\_\_\_

Signature of Witness: X \_\_\_\_\_

**PRODUCER CERTIFICATION**

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Signed at: \_\_\_\_\_ 09/22/2019  
(City and State) Date

X Signature Submitted Electronically Protective Life  
Producer Signature Producer Name (Print) 000Q0DC331





Protective Life Insurance Company  
P.O. Box 830619, Birmingham, AL 35283-0619  
Telephone: 800-366-9378

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

NOTICE REGARDING REPLACEMENT

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing your policy.

You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

X Flora Tarcila E. Apelo  
Flora Tarcila E. Apelo (Sep 28, 2019)

09/28/2019

Signature Submitted  
Electronically

Applicant's Signature Flora Tarcila E Apelo

Date

Agent's Signature YOO, BYUNGSEUNG

000Q0DC331

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

Name of Applicant: Flora Tarcila E Apelo D.O.B. 04/06/1964

Address: 140 Mirror Ct Patterson, CA 95363

Proposed Insured if Other Than Applicant: \_\_\_\_\_

Application Number of Proposed Insurance: LU5343591

The following policy(ies) may be replaced as a result of this transaction:

POLICY INFORMATION

AAA LIFE INS. CO.  
Insurer: \_\_\_\_\_

Policy Generic Name: Term Life

Policy Number: 4003827716

POLICY INFORMATION

Insurer: \_\_\_\_\_

Policy Generic Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

POLICY INFORMATION

Insurer: \_\_\_\_\_

Policy Generic Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

POLICY INFORMATION

Insurer: \_\_\_\_\_

Policy Generic Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_



Protective Life Insurance Company  
P.O. Box 830619  
Birmingham, AL 35283-0619

#### NOTICE AND CONSENT FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named above, Protective Life Insurance Company, has requested that you provide a sample of your blood, urine, or saliva for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

#### Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

#### Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

#### Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

#### Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: Thao Pham

Address: 770 E. Calaveras Blvd. Milpitas CA 95035

If you do not wish to know the results of the test, initial here:                     . In the event the test is positive and you are denied coverage because of the fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here:                     . The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

#### Consent

I have read and I understand this Notice and Consent for AIDS-Related Testing. I voluntarily consent to the withdrawal of blood, urine, or saliva from me, the testing of that blood, urine, or saliva, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

Flora Tarcila E Apelo

Name of Proposed Insured (Print)

140 Mirror Ct Patterson, CA 95363

Address

U-592-CA

X Flora Tarcila E. Apelo  
Flora Tarcila E. Apelo (Sep 28, 2019)

Signature of Proposed Insured or Parent/Guardian

X 09/28/2019

Date Signed

7/2014

LU5343591

Flora Tarcila E Apelo



## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

### USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

- obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
- obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
- use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
- use any information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

### RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

- my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
- medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
- insurers; reinsurers;
- my (our) current and previous employers;
- MIB, Inc. (MIB); and commercial consumer reporting agencies (CRA).

All of these persons and organizations other than MIB may release the information described above to a CRA acting for Protective Life. MIB may not release the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to a CRA.

### TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include, but are not limited to:

- tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS, see **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING** section).
- tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

### RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section and the **TESTING OF BLOOD, ORAL FLUIDS AND URINE** section:

- to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, MIB and as otherwise required by law.
- to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
- to its reinsurers, to make a brief report of my personal health information to MIB.
- to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
- to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

Home Office – ORIGINAL      Applicant - COPY

### SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I (we) hereby authorize Protective Life:

- a. to obtain and use the results of any HIV tests that I (we) separately authorize.
- b. (if permitted by law) to disclose the results of any tests to its reinsurers and MIB.

### GENERAL INFORMATION

- a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or, in the event of a claim for benefits, for the duration of such claim.
- b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
- c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
- d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
- e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
- f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

### AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

- ☒ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.
- ☐ I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

**THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.**

### SIGNATURES

Date of Authorization: X 09/28/2019

\_\_\_\_\_  
List Health Care Providers

Flora Tarcila E. Apelo  
Flora Tarcila E. Apelo (Sep 28, 2019)

|                                         |                                           |                                |                                              |
|-----------------------------------------|-------------------------------------------|--------------------------------|----------------------------------------------|
| _____<br>Proposed Insured 1 (Signature) | _____<br>Print Name of Proposed Insured 1 | <u>04/06/1964</u><br>Birthdate | <u>413-83-6677</u><br>Social Security Number |
|-----------------------------------------|-------------------------------------------|--------------------------------|----------------------------------------------|

|                                              |                                           |                    |                                 |
|----------------------------------------------|-------------------------------------------|--------------------|---------------------------------|
| X<br>_____<br>Proposed Insured 2 (Signature) | _____<br>Print Name of Proposed Insured 2 | _____<br>Birthdate | _____<br>Social Security Number |
|----------------------------------------------|-------------------------------------------|--------------------|---------------------------------|

|                               |                                                    |                                                 |
|-------------------------------|----------------------------------------------------|-------------------------------------------------|
| _____<br>If Minor, Print Name | X<br>_____<br>Parent or Legal Guardian (Signature) | _____<br>Print Name of Parent or Legal Guardian |
|-------------------------------|----------------------------------------------------|-------------------------------------------------|

Home Office – ORIGINAL

Applicant - COPY



Protective Life Insurance Company  
P.O. Box 830619  
Birmingham, AL 35283-0619

## ELECTRONIC POLICY DELIVERY ELECTION FORM

Protective Life offers Electronic Policy Delivery (EPD), the option to receive your policy in an electronic printable format instead of paper. The policy will be electronically sent to you by email and stored on our secure Customer Service website, [www.myaccount.protective.com](http://www.myaccount.protective.com), which is available 24 hours a day.

### How Electronic Policy Delivery will work for you:

- The EPD process is quick, easy and safe.
- You can save, print, and review your policy online 24 hours a day, 7 days a week.
- Your policy will be safely stored on our secure website for convenient easy access.
- You can make your initial payment online by bank draft or credit card.

### How to sign up for Electronic Policy Delivery:

1. Provide your email address below.
2. Return this form with your application for life insurance.

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**By providing my email address, I am requesting my policy to be delivered through Electronic Policy Delivery.**

ftapelo@aol.com

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Email Address for Proposed Insured

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Email Address for Owner

(If the owner is other than the proposed insured)



Protective Life Insurance Company  
P.O. Box 830619  
Birmingham, AL 35283-0619

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under California law, you have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy is in danger of lapsing.

If you wish to name a secondary addressee, please call us at 1-800-366-9378, or fax us at 1-205-268-5807, or write us at P.O. Box 830619, Birmingham, Alabama 35283-0619.

Please Print the Following Information:

LU5343591  
Policy Number (if known)

Flora Tarcila E Apelo  
Policy Owner's Name

Flora Tarcila E Apelo  
Insured's Name

Secondary Addressee:

Name

Street Address or P.O. Box

City, State, Zip Code

Telephone Number



Protective Life Insurance Company  
P.O. Box 830619  
Birmingham, AL 35283-0619

## DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, Inc. Notice and Fair Credit Reporting Act Notice)

### **DISCLOSURE OF INFORMATION**

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, Inc., (MIB), formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

### **INVESTIGATIVE CONSUMER REPORT**

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report by making a written request to Protective Life, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

### **YOU CAN REVIEW AND CORRECT YOUR INFORMATION**

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see a copy of the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent/producer for assistance or call or write us at Protective Life Insurance Company, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

## **THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED**

### **AGENT/PRODUCER COMPENSATION DISCLOSURE**

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.